JUN 18 1987

THE SAINT JOHN MENTAL HEALTH CLINIC STUDY

FILED
JUN 11 1987
CLERK'S OFFICE

Report

April 1987

SUMMARY

An assessment of current program activity was conducted at the Saint John Mental Health Clinic in order to determine the proportion of the adult case load requiring psychiatric or psychosocial services.

Approximately 80% of the adult case load, those receiving continuing care and new admissions, require and are receiving care for psychiatric disorders.

Psychosocial case load needs, about 20% of the adult case load, are represented by those who are experiencing a situational maladjustment due to problems of living, work, relationship, and love, leading to anxiety, depression, and stress related responses.

Psychosocial services of a rehabilitative nature are being provided to those patients whose psychotic symptoms are in remission or under control due to ongoing maintenance of medication and systematic follow-up.

The major part of the Clinic activity is directed to assessment, treatment and after care of psychiatric patients. It is appropriate to include these services within the "Institute" model set out in the Mental Health Services Delivery Study.

Most of those patients identified as requiring psychosocial intervention must be assessed to determine whether a psychiatric disorder is present before a decision can be made to proceed with short term counselling. These case load activities are properly a responsibility within the case load of the "Institute".

The Day Rehabilitation and vocational programs could be relocated and could be assigned as an after care or psychosocial services program to an agency such as the proposed Aftercare Services Committee.

However, continuing medication monitoring, crisis intervention and follow-up will remain the responsibility of a psychiatric services agency.

More resources are needed to meet service needs.

The Transition Team meetings between Centracare and the Mental Health Clinic should be reinstituted.

A patient oriented information system should be developed.

Consideration should be given to greater use of Clinic computer resources in clinical practice and for planning purposes.

THE SAINT JOHN MENTAL HEALTH CLINIC STUDY

1. INTRODUCTION

In response to the New Brunswick Region 2 Mental Health Services Delivery Study, the Department of Health and Community Services has provisionally accepted the following:

1. the recommended organizational model and operational concepts;
2. the development of a multi-disciplinary team approach within an organizational model involving a network of integrated services;
3. the feasibility of implementation throughout the province;
4. that there are important components of service existing within the Mental Health Clinic program which should be incorporated as part of the integrated service network and there are other components which need not; and
5. that it is important to determine how these components of the Mental Health Clinic services should relate to the proposed mental health delivery system.

It is recognized that the Mental Health Clinic:

1. relates to a broadly based referral system; and
2. serves clients with a wide spectrum of mental health and social problems.

It is important therefore to determine on the basis of a client centered approach, i.e., in relation to client needs, what resources are identifiable and available to serve these people who come or are sent to the Mental Health Clinic for treatment of mental disorders. Once this determination is made, i.e., the kind and scope of needs, it will be possible to identify the organizational relationship and the allocation of resources which should be made.

In order to determine the scope and manner in which the Mental Health Clinic services should relate to the recommended mental health delivery system, it was decided that a study of current clinic activity be undertaken.

2. STUDY METHOD

Documents pertaining to Mental Health Clinic activity and to rehabilitation and follow-up were reviewed (Appendix 1); information on 100 cases representing the current case load of clinic staff was obtained; clinic files on the 95 consecutive admissions prior to January 27, 1987 were reviewed; interviews were held with Barry Reimer, Jim Martin, and Judy Winters of the clinic; an adult clinic team meeting was attended at which 27 new clinic cases were assigned; a meeting was held with the day program rehabilitation team; Elizabeth Polley, Supervisor of Adult Services of Department of Health and Community Services and director of the Centracare Placement Project was interviewed, as was Dr. Mary Goodfellow, a family physician, Kato Abblitt, Director of Professional Services at Centracare and Gregory Zed, Coordinator of Social Work at Centracare.

3. MENTAL HEALTH CLINIC MANDATE

In 1968, "the network of regional mental health clinics was established....to make accessible to the population of New Brunswick an out-patient diagnostic treatment and counselling service in order to avoid hospitalization whenever possible....All new admissions to the two (2) psychiatric institutions were to be screened by the community mental health clinics. A cardinal role for the new community mental health services was the follow-up and continuing treatment of former patients of the (2) psychiatric institutions."(8)

The Saint John Mental Health Clinic has three service teams which are responsible for Child*, Adult and Rehabilitation services. The adult team, which is multi-disciplinary, includes nurses, psychiatrists, psychologists, and social workers, who provide out-patient assessment, crisis intervention, treatment, and consultation services. This team uses a primary therapist one-to-one model. The rehabilitation team is also multi-disciplinary, and includes psychologists, social workers and an educational technician, who work on a case management, social educational model.

The clinic staff feel themselves the subject of criticism because of "their inability to provide adequate after care services."(8) They are attempting to respond to the Departmental directive to allocate resources to the 5% prevention, 55% treatment and 40% rehabilitation targets.

The original mandate established in 1968 has changed, e.g., this clinic does not provide preadmission assessment for people referred to Centracare, there has been an increased emphasis on after care and follow-up with significant expectations that, "the critical focal point to the entire community mental health system <u>is</u> the mental health clinic".(3) The clinic is "responding to an increasing broad based demand for general mental health services....to provide assessment and treatment of pre-defined mental health problems...Aftercare/follow-up of patients discharged from inpatient units...Provision of rehabilitation services to chronically mentally ill...clinics currently service about 1% of population, whereas they should be servicing about 3% requiring serious intervention..."(4) Increased

---

* Child services were not considered in this study.

expectations in the face of uncertainty about priorities, within an uncoordinated system and a shortage of resources has created problems for clinic response.

As a consequence, goals and objectives have not been clearly stated except to respond to requests for service as effectively as possible. With regard to follow-up services, the clinic is expected to manage chronic patients who are most difficult to place and to maintain in the community.

Patients included within the Centracare Placement Project were awarded considerably more resources to make the transition to the community.

4. REFERRAL PATTERNS

From information based upon 1986 data, about 60% of new referrals to the Clinic are over 16, about 70% of reregistrations are over 16 and about 78% of active cares are over 16. Mr. Reimer, in earlier correspondence indicated that there are 300 chronic cases being maintained by the adult team. These patients require ongoing monitoring and administration of medication and periodic intervention of a crisis nature. About 90% of these cases are former Centracare residents.

The following referral sources for adults can be identified:

	NEW		REREGISTRATIONS			
	M	F	M	F	T	%
Self	45	78	60	102	285	32.0
Physician	39	72	10	11	132	14.8
Social Services	8	10	8	11	37	4.2
School	4	1	1		6	.7
Family	19	22	27	17	85	9.5
Public Health				3	3	.3
Hospital	5	8	3	4	20	2.2
Mental Health	1	1	1		3	.3
Centracare	19	15	11	14	59	6.6
Walk-in	33	48	60	29	170	19.1
Justice	14	8	11		33	3.7
Other	16	8	32	3		6.6
	203	271	224	194	892	100.0

About 50% are either self-referred or walk-in clients, about 15% are physician referred and about 10% are family referred, accounting for a total of 75% of adult referrals in 1986. Centracare referrals accounted for less than 7%. It should be noted that many self-referrals and walk-in patients are sent by other referral agents indirectly. For example, a physician may suggest that a person go to the Clinic but the physician does not make a direct referral. This probably occurs in the case of less critical cases. However, those who have received services from the Mental Health system, sometimes from the Clinic directly, may consider it desirable to seek services due to a crisis and therefore refer themselves or walk-in. Further examination of self-referrals and walk-ins would be necessary to determine factors influencing their use of the Clinic.

It was suggested that there are other influences affecting referral patterns to the clinic. A referring physician pointed out that some patients prefer to attend a private psychiatrist because of the Clinic's "public" nature, the inability to refer directly to a specific professional in the Clinic and concern about confidentiality. The physician also stated that referrals to the clinic are made if it is anticipated that patients have psychosocial as well as psychiatric problems. Acute episodes are referred to the emergency department of the regional hospital. "Better educated" patients will be referred to private psychiatrists if the problem is "only" psychiatric. Those requiring a wider range of services will be referred to the clinic.

Information gathered by the clinic is in general agreement with these observations. It indicates the referral population is composed of multi-problem persons within and below lower middle class. Others tend to seek services elsewhere.

5. PSYCHIATRIC AND PSYCHOSOCIAL NEEDS

In order to determine the proportion of patients who have either psychiatric or psychosocial needs as primary, 100 patients were drawn from the current case load of the adult team. From the information provided on these patients, a categorization was made on the basis of the following criteria:

Psychosocial: situational maladjustment; problems of living, work, relationships and love leading to anxiety, depression, and stress related responses.

Psychiatric: obvious personality disorders; schizophrenic disorders; affective disorders; serious sexual deviation; obvious and serious substance abuse.

The following categorization was obtained:

Case Load

	Female		Male	
Age	Psycho-Social	Psychiatric	Psycho-Social	Psychiatric
<20	2	3		2
20-29	3	8	2	13
30-39	5	19	3	7
40-49	2	9		9
50-59	1	2	1	4
60-69		2	1	1
70-79		1		
	13	44	7	36
	22%	78%	16.3%	83.7%

From this review of the case load, it is clear that by far the largest portion of the case load, 80% are receiving and require psychiatric care.

It was equally important to assess those being admitted to the clinic to compare these proportions with the current case load since it could

be assumed that the gradual accumulation of patients suffering from chronic conditions would increase the psychiatric to psychosocial proportion. Such was not the case. The 95 consecutive admissions prior to January 27, 1987 were reviewed and categorized as follows:

Admissions

Age	Female		Male	
	Psycho-Social	Psychiatric	Psycho-Social	Psychiatric
<20	1	3		1
20-29	3	13	2	11
30-39	9	11	2	13
40-49	3	4		3
50-59		3		1
60-69		1		1
70-79		2	1	1
80-89		1		
	16	38	5	36
	29.6%	70.4%	12.2%	87.8%

The review of admissions indicated that the overall admissions proportions are similar to the case load proportions, 79.9% and 80% psychiatric and 20.1% and 20% psychosocial respectively. In both groups there is a somewhat larger proportion of females presenting psychosocial problems, a relationship which might be expected. In addition, it seemed more likely that a larger proportion of those presenting with psychosocial problems would be self-referred and such proved to the the case. Of the 21 psychosocial cases, 16 were self-referred, three women were referred by family practitioners, one women by a court social worker and one man by a community social worker. Self-referrals of women with psychosocial problems, 75%, were much higher than self-referrals of those with psychiatric problems, 26.3%. Similarly, self-referrals of men with psychosocial problems, 80%, were higher than self-referrals of those with psychiatric problems, 33%.

6. ADMISSIONS PROCEDURES

There are eight members on the adult team including two psychiatrists, three nurses, one full time and one half time social worker, and two psychologists.

Adult team members are assigned on a rotating basis as duty workers with responsibility for intake on designated days. The duty worker will make an initial assessment at the time contact is made with the referral agent to determine whether the person being referred is experiencing problems or difficulties which are appropriate for intervention by clinic staff. During this referral process, the duty worker will redirect or refer elsewhere, those who clearly have problems, such as marital conflict for example, and who do not give evidence of a psychiatric disorder. Obviously, in the case of some referrals it is not possible to determine the severity of a depression, the degree of debilitation caused by the anxiety or the stress which is described, and it is necessary and proper to admit and conduct an assessment. In the case of some patients, the problems may therefore turn out to be primarily psychosocial, and relatively easily dealt with in one or two counselling sessions.

During the adult team clinical session, the patient assignments were made on the basis of expected severity, type of problem and criticalness. In several cases, since they were readmissions, patients were know to team members, and assignment was relatively routine. Upon assignment, the team member becomes the primary therapist for the patient and will seek consultation and assistance from other team members as required.

Patients are assigned to primary therapists in relation to the type and severity of the presenting problem, consultation is obtained as

requested by the primary therapist who is responsible for developing and carrying through the treatment and discharge plans.

The case load carried by the Clinic appeared to be a case load typical of most Community Mental Health clinics.

7. PSYCHOSOCIAL/PSYCHIATRIC PROGRAM REQUIREMENTS

The psychosocial needs of those adults attending the clinic fall into two groups at either end of the continuum of severity. About 20% of those referred exhibit some type of situational maladjustment due to problems of living, work, relationships and love, of sufficient severity to produce anxiety, depression and stress related responses. The break up of a marriage, loss of employment, death of a spouse or other serious life crisis cause such responses. Until an assessment is made, it is sometimes difficult to determine whether the depression, anxiety or stress response requires psychiatric intervention or short term counselling or both. In any case, most of these referrals are appropriate and will benefit from the service provided by the clinic.

About 80% of those adults referred to the Clinic are suffering psychiatric disorders to some degree. Many of these patients are experiencing multi-problem difficulties and may have psychosocial service needs also but their primary need upon referral, is psychiatric intervention.

At any one time, the Clinic provides ongoing monitoring, supportive and maintenance care for upwards of 300 chronic patients. Most of these are former Centracare residents but a few are added to this group for continued maintenance who have not been admitted to Centracare. Many of these patients need ongoing psychosocial support as well.

The Clinic also operates a day rehabilitation program for 26 patients (five or six places are reserved for Centracare patients) which is directed at developing living and social skills. This is a three month program, although patients may participate in the program more than once. Since not each person remains in the program, it is usually possible to admit a person to the program at the time of referral rather than requiring the person to wait until the next three month session begins. Patients referred are judged by the prime therapist to be likely to benefit from the program and enter the program if they agree to do so. In some cases considerable encouragement and support is required initially.

There is a vocational rehabilitation program which is directed at teaching people vocational skills and getting them placed in regular employment in the community. Many of these patients are former Centracare patients. There are currently about 50 patients placed in employment who are being monitored and maintained.

The patients in the Day Rehabilitation and Vocational programs are in need of psychosocial services to assist them to learn living, social, work, and recreational skills. It is necessary, if patients are to participate in these programs, that they be properly maintained on a follow-up and monitored program. The Mental Health Services Network Committee in the Position Paper on Aftercare stated that, ".... the ingredients deemed essential to obtain success (defined as a reduction of number of hospitalizations and improved quality of life in the community) are crisis intervention, appropriate medication, intervention with significant others and continuous follow-up". This statement, and the identification of resources which are required, make clear the significant role of medical/psychiatric monitoring.

It is not possible to estimate the proportion of the case load which could be monitored by family practitioners without a detailed case by case study, but it is evident that if closer liaison were established with community physicians some portion of the case load could be managed by them. It would be necessary to provide information, consultative support and regular review for them, but the long term resource saving would likely warrant the effort. It is accepted that not all community physicians would be interested, but there is little doubt that some would be and they could be "recruited" to help in the monitoring process. Information from 1986 data indicates that only about 15% of patients are referred directly by physicians to the Clinic. Examination of case records indicate that a significantly larger proportion of patients have family physicians and it expected that many of them would agree to participate in after care follow-up.*

The move from supervised institutional care to independent or semi-independent living is seen as most effective when there is a gradual transition. Centracare provides a Day Rehabilitation program directed at teaching or improving living, social and recreational skills within the institutional setting. An arrangement with the Mental Health Clinic makes it possible for transfer of patients from this program to the Day Rehabilitation program in the Clinic. (Five or six spaces are allotted to Centracare for this purpose.) About six weeks into the three month program, an attempt is made to find suitable living accommodation in the community. The patient continues in the Day Rehabilitation program so that the transition is made

---

* One family physician indicated interest in participating more directly on behalf of her patients.

from institutional care to appropriate community living in a manner best suited to patient needs.

The relationship between Centracare and the Mental Health Clinic, relative to the Day Rehabilitation programs, seems to have worked well in the past and continues as an ongoing rehabilitation effort. In order to facilitate this and other programs and to, "Make sure both facilities maximize current resources", a Transition Team was established in November 1981 and met on a regular basis until October 1983, submitting a report in the spring of 1982 recommending that a permanent transition team be established, ".... to handle the problems, and expedite the cooperative efforts recommended in this report". The work of the team seemed to facilitate communication and to assist in the transition of patients from one service to the other. In the minutes of the team meeting on March 21, 1983, for example, "A tentative proposal was discussed for assuring prompt follow-up of discharged patients in an effort to promote better compliance with aftercare appointments.

1. An appointment will be made with the attending psychiatrist for two weeks following discharge, and with the follow-up Community Mental Health Nurse for the day of discharge or the following day....

2. The Community Mental Health Nurse will contact the social worker assigned to a patient followed by her prior to admission, and arrange to visit the patient while in hospital at least once prior to discharge."

It is not clear why the team meetings ceased since they were providing a necessary co-ordinating function.

8. CLINIC ROLE

Based on the 1986 data, and from this assessment, it would appear that psychiatric patients represent about 80% of the active adult case load of the clinic. Decisions will have to be made regarding the manner in which service components should be integrated into the proposed "Institute" model.

1. Psychological Services

During one year the Clinic currently provides assessment, diagnosis and counselling for about 125 female and 50 male cases requiring short term psychosoical intervention (based on 1986 data). There are few other sources in the community for provision of psychosocial services and it is expected that an increase in such services to meet the needs of those requiring them would be desirable. Initial assessment is required in many cases to make a differential diagnosis. The initial "triage" function is appropriately conducted where both psychiatric and psychosocial expertise is available. Whether the supportive psychosocial services should also be provided as part of the "Institute" mandate will have to be decided. If not as an "Institute" mandate then a decision must be made as to jurisdictional responsibility.

2. Psychiatric Services

The Clinic currently provides assessment, diagnosis and treatment for about 350 female and 375 male cases on an out-patient basis during a year (based on 1986 data). The provision of these out-patient psychiatric services is, properly, within the mandate of the "Institute". The location of these services "downtown" is appropriate inasmuch as it facilitates accessibility. The location seems convenient to the population being served, both psychosocial and psychiatric. Other locations may enhance greater use by other populations of clients.

3. Follow-up, Aftercare

Follow-up, aftercare services are provided to about 300 chronic cases, about 90% of whom are discharged Centracare patients. This service is within the mandate of the "Institute" since these patients require monitoring of medication, crisis intervention and continuing follow-up. Some of these services can be provided by others, such as family physicians, but the need for continuing psychiatric consultation makes it mandatory to have psychiatric expertise readily available and, therefore, appropriately, within the responsibility of the "Institute" to provide.

4. Rehabilitation Vocational

The Day Rehabilitation program serves about 60 patients per year and there are currently about 50 patients in the Vocational program. It is necessary to have psychiatric consultation available to those responsible for the program and services available to patients but these programs could be relocated to suitable quarters elsewhere and/or become the responsibility of the proposed Aftercare Service Committee.

As the evolution of the proposed model proceeds, consideration should be given to the location and function of clinic components, i.e., children's services, adult psychiatric, psychosocial, and follow-up rehabilitation services. Upgrading and possible relocation of the physical facility must be considered especially if other clientele will be expected to use the "downtown" out-patient "Institute" services. It will be necessary to review the Policy Manual Mental Health Services (6), the Policy Manual of Intake Procedures (7) and develop a comprehensive Policy Manual for out-patient clinical services. The need for out-patient program standards has already been anticipated and, we understand, is in process of development. In this process there would be value in conducting an operational review of this and other clinics to determine current operating practice with regard both to efficiency and quality of care. For the Saint John Mental Health Clinic, no matter what decisions are made, a number of issues must be addressed.

1. All services are currently under resourced as indicated in the Mental Health Services Delivery Study.

2. The Transition Team or some similar liaison committee should be reconstituted to work on co-ordination, communications, effective resource utilization and patient service issues. (One of the reasons the team may have ceased to meet may have been the time required for its work.)

3. A patient oriented rather than program oriented information system should be instituted. Current systems indicate how many patients were seen, how many interviews were provided etc. by each service or department. It would be much more helpful for planning purposes to know how many services were received by each patient. It is more important, for example, to know that Mary Jones received X, Y, Z services and improved, than that the outpatient service saw X number of patients and provided Y number of interviews. Such a system will provide a better vehicle for the development of program outcome assessment and for more effective allocation of resources. It may then be determined how much service was required by what types of patients and what the results were.

4. An attempt should be made to utilize new computer program resources which are appropriate to Mental Health Clinic practice. Two program diagnostic systems were purchased and assessed for this study. Their use in clinic practice should be explored and might be found advantageous for clinic work. The Clinic has some computer resources available to staff. These should be exploited to the full in any manner which will assist in more effective use of staff clinic time and in assessing and planning activities.

APPENDIX 1

DOCUMENTS REVIEWED

1. Building Community Based Suport Systems for Citizens with Mental Handicaps. A Progress Report. New Brunswick Association for Community Living. December 1986

2. The Centracare Community Placement Project - An Overview. Elizabeth Poley. March 1987.

3. Initiatives for Community Based Mental Health in New Brunswick. Canadian Mental Health Association, New Brunswick Division. December 1986.

4. Mental Health Services in New Brunswick. Overview and Master Plan. December 1985.

5. New Brunswick Region 2 a Mental Health Services Delivery Study.

6. Policy Manual Mental Heath Services Department of Health, New Brunswick. October 1980. Revised 1982.

7. Policy Manual of Intake Procedures. April 1984.

8. Position Paper on Aftercare. (Draft.) The Mental Health Services Network Committee. January 1987.

9. Physical Fitness: Skill Development Through the Use of Existing Resources in Saint John, New Brunswick. Forum, No. 7, July 1986. National Mental Health Services Committee, Canadian Mental Health Association.

10. A Prototypical Staff Development Model for Communitization Projects. Peter H. McGuire. 1987.

11. Standards for Psychosocial Rehabilitation Services. New Brunswick Department of Health and Community Services. November 1986.

12. Transition Team Report. Draft. March 30, 1982.

13. V.R.D.P. (Vocational Rehabilitation Disabled Persons) Program Standards and Guidelines. 1981.

END OF TEXT